

DO NOT TEAR OUT

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
 County Jackson
 Civil Dist. 6
 OR
 Village _____
 OR
 City _____ (No. _____, St.; _____ Ward)

STATE OF TENNESSEE
 STATE BOARD OF HEALTH
 Bureau of Vital Statistics
CERTIFICATE OF DEATH
 5293
 Registration District No. 44406
 Primary Registration District No. _____
 File No. 3
 Registered No. _____
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Daisy Simpson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F **4 COLOR OR RACE** white **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** infant
(Write the words)

6 DATE OF BIRTH 12 / 1 / 1928
(Month) (Day) (Year)

7 AGE 1 yrs. 1 mos. 0 ds. If LESS than 1 day, _____ hrs. or _____ min.?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work. infant
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Jackson, Co.

PARENTS

10 NAME OF FATHER Wash Simpson

11 BIRTHPLACE OF FATHER [State or country] Jackson, Co.

12 MAIDEN NAME OF MOTHER Minnie Cox

13 BIRTHPLACE OF MOTHER [State or country] Jackson, Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 [Informant] John Coplan
 [Address] Gainesboro Tenn

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 / 1 / 1929
[Month] [Day] [Year]

17 I HEREBY CERTIFY, That I attended deceased from _____, 192____, to _____, 192____,
 that I last saw h_____ alive on _____, 192____,
 and that death occurred, on the date stated above, at _____ M
 The CAUSE OF DEATH* was as follows: 2056
no doctor
 [Duration] _____ yrs. _____ mos. _____ ds.
 [Duration] _____ yrs. _____ mos. _____ ds.
 Signed _____, M. D.
 _____, 192____ Address _____

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS TRANSIENTS, OR RECENT RESIDENTS]
 At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted, if not at place of death? _____
 Former or usual residence _____

15
 Filed March 6, 1929 Mrs. T.H. Norton
 REGISTRAR

19 PLACE OF BURIAL OR REMOVAL New Hope Cemetery **DATE OF BURIAL** Jan 2, 1929

20 UNDERTAKER Bill Young **ADDRESS** Gainesboro Tenn